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First Illinois *Speaks*

HFMA's First Illinois Chapter Newsletter

January 2015

LEADING *the* CHANGE

hfma 2014 - 2015

Highlights and Recap
First Illinois Chapter Events
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News, Events & Updates



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A Message from Joseph J. Fifer, FHFMA, CPA

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION PRESIDENT AND CEO

I've had a song stuck in my head for the past several days. And, as annoying as it can be to have Andy Williams on a continuous loop, I have to agree with him—this really is the most wonderful time of the year. From the festivities to the food to the family gatherings, there are many reasons to love the holiday season. It's also a perfect time to take stock of the past year and to recognize those who've taken this journey with us.

Looking back over the past 12 months, it's clear that we've made significant progress in our quest to lead the financial management of health care. I am in awe of your achievements and amazed by your passion and commitment to the association. I would like to take a moment to share my thoughts on some of our key accomplishments.

HFMA articulated a "three circles" strategy to reflect the convergence taking place in the industry. This strategy signifies our commitment to promoting collaboration among the three stakeholder groups who play a major role in achieving the Triple Aim: payers, physicians, and hospitals. In support of this

effort, we established four new Affinity Groups, including payer health economics executives, academic medical center CFOs, physician practice administrators and value chief strategy officers.

I am pleased to report that we continue to provide our members with much-needed best practices for the ever-changing healthcare industry. This year, we added two new Value Project reports to encompass value-focused acquisitions and affiliations as well as physician engagement and alignment.

A task force led by HFMA, made up of healthcare leaders and consumer representatives, reached a consensus on how consumers can obtain clear and easy-to-understand information about their financial obligation for healthcare services. Their recommendations are set forth in the Price Transparency in Healthcare report, which has earned us a spot on a list of price transparency movers and shakers published by George Washington University. In addition, a working group of the task force developed Understanding Healthcare Prices: Consumer Guide, a resource for consumers that

(continued on page 2)



A Message from Joseph J. Fifer, FHFMA, CPA

(continued from page 1)

is offered to patients as an online resource by hundreds of providers and other healthcare organizations. I would like to thank all who participated—your contributions have been invaluable.

We continued our work with patient financial communications. HFMA took pride in rolling out the Patient Financial Communications Training Program. This online educational resource addresses an unmet need in the marketplace and elevates financial interactions with patients to the importance they deserve. Information about all of our published reports can be accessed at hfma.org.

HFMA ended FY2014 with more than 40,000 members, including a record increase in student memberships. Our membership continues on a healthy track for FY2015, and we anticipate ending the year with over 40,000 members. Our members realize the value of the products and services HFMA offers—they are proud to be a part of the “HFMA Family.”

Reflecting the importance of reaching beyond our core membership, we increased the publication frequency of *Leadership*, the magazine that highlights collaborative efforts to redefine and redesign healthcare delivery. The print magazine circulation is more than 75,000 stretching across the C-suite and other healthcare leaders, in hospital, physician, and payer settings.


More than 500 organizations now participate in HFMA's MAP App online tool for improving revenue cycle performance. In 2014, we recognized 19 hospitals and health systems with MAP Awards for High Performance and Performance Improvement in Revenue Cycle. Starting next year, physician practices will also be eligible for MAP Awards.

Our educational impact continues to be impressive, equating to more than half a million education hours per year. The majority is delivered at the local level by our HFMA-strong network of 68 chapters and 11 regions. At the national level, we introduced the Value Summit, an interactive program that enabled finance leaders to operationalize value in their own organizations and share their value journeys with their peers.

It's important to mention that HFMA has moved to the next level on the national stage. From presentations to agencies like the Federal Trade Commission and the Consumer Financial Protection Bureau to filing a Supreme Court amicus brief, we are making our voice heard—now more than ever.

As 2014 draws to a close, I'm sure you'll agree that we all have much to celebrate. You have made everything we do with our members and our business partners possible. I am grateful for the important role you play in helping shape HFMA in becoming the recognized leader in healthcare finance. I'm excited about what lies ahead and, together, I'm confident we'll raise the bar even higher in 2015.

In lieu of sending print cards, HFMA has made a donation to the Ronald McDonald House near Lurie's Children's Hospital (Chicago) and the Ronald McDonald House Charities of Greater Washington DC. The Ronald McDonald houses provide a “home away from home” for families whose children are receiving treatment at nearby hospitals.

As you gather with your families and friends, I wish you joy and peace this holiday season. Many blessings to you and yours during this most wonderful time of the year! All my best—Joe 



Joseph Fifer



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President's Message

As we continue to meet the challenges in our part of the healthcare world, we can feel fortunate that we belong to an industry that is exciting and robust. The First Illinois Chapter of HFMA continues to reach for new ways to provide resources to its 1,400 members. The chapter year is half over as we enter 2015. FIHFMA will provide over 17,000 education hours by the time we hit June. It is very exciting for the board and officers to be able to see the results of our efforts as 400 attended our last educational program, the Fall Summit. So what is in store for 2015? Have you made your plans and goals? Are you looking to advance your career into new territory?

The chapter is bustling with programs and events. The Managed Care Program takes place at the end of January, and the Spring Summit is set for April. A myriad of free webinars are scheduled and can be found on our web site. And there are some fun social events on the horizon. In February, the chapter is hosting our second Certification Practicum. The free training and testing allows you to achieve the CHFP designation, a highly sought after and prestigious recognition. Please visit www.firstillinoisfhfma.org for all of the happenings this year.

I am truly humbled and proud to lead the chapter through the rest of this year. However, it takes a strong team to execute the strategic plan. Many thanks to all of the committee chairs and members, board members and fellow chapter officers, Adam Lynch, Mary Treacy-Shiff and Brian Katz. We also acknowledge the chapter sponsors who continue to support FIHFMA. Please let us know what you are thinking about and how we can meet your needs. I look forward to seeing all of you at the next event! 🍷



Carl Pelletieri
2014 – 2015 First Illinois,
HFMA Chapter President

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New Year's Career Resolutions—From HFMA Members to You

BY VICKIE AUSTIN

Another new year is upon us and what better time to reflect on our careers? To help you ignite your own career this year, I asked HFMA leaders, "What is the **one thing** you recommend HFMA members do to advance their careers in 2015?"

With my hearty thanks to those who responded, here's some sage advice from your fellow HFMA members on how to take your career to the next level in 2015:

Help Others

Paula Dillon just made a big transition from working for a hospital to a new job as director of managed care for the Illinois Hospital Association. Her New Year's Resolution is to help others more.



Paula Dillon

"A career is a two-way path, comprised of our self-directed efforts as well as the mentoring, support and guidance from colleagues," she said. "My goal in 2015 is to remember that two-way path and ensure that I reciprocate, to be as supportive to those in need as I was supported by colleagues in recent times."

She added that this year she isn't going to wait until others ask for help. "I'll proactively reach out just to say, 'Hello, how are things going? How can I help further your own progress?'"



Katie White

Take Time to Network

Like Paula, **Katie White** recommends revving up your networking in the new year. "One thing that I would recommend would be to get out there and get involved," said Katie, who is a senior accountant at the Metropolitan Chicago Healthcare Council.

"Get to know people in your industry, in every department. Not only is professional networking crucial to your career success, but it will give you knowledge and skills that make you a better employee and an asset to your company," Katie said.

Focus on Collaboration

Several members made the strong recommendation to collaborate in the new year, including guidance from the national chair of HFMA's board of directors, **Kari Cornicelli, HFMA, CPA**.

"One piece of advice I have for my fellow HFMA colleagues is to develop collaborative relationships with your fellow colleagues and physicians," Kari wrote from Sharp Metropolitan Medical Campus in San Diego, Calif., where she recently was promoted to VP and CFO. "2015 will be a year of continued challenges and change," she said, a reflection of her theme for HFMA for this year, "Leading the Change."



Kari Cornicelli

"To continually improve quality and care processes, and to eliminate waste and reduce costs, we need a fully integrated team that is rowing in the same direction. We need to value and rely on the expertise and input of all key stakeholders," Kari said.

She added that "financial leaders should be model developers of relationships to ensure the success of their organizations—and their careers!"

Carl Pellettieri, principal of Impact Healthcare Services and president of this First Illinois chapter's board of directors, couldn't agree more.

"My advice would be to step out of your comfort zone by getting to know another healthcare professional," shared Carl. "That could be a doctor or a nurse. Ask them about their perspectives and ideas regarding healthcare finance. As we know, many of the leading provider organizations like Mayo, Cleveland Clinic and Geisinger are led by physicians."

Then, he urged, "Share your thoughts with them. As the previously independent spheres become closely interdependent, there is much to be learned from each other."



JV Maganti

Active collaboration was also the recommendation of **J.V. Maganti**, MS, MBA, FACHE, president and CEO of Guava Group, Inc., who said collaboration is the key to the future.

"Healthcare finance professionals can no longer survive if they just know number crunching and accounting principles. To succeed we need to move beyond our traditional boundaries and

actively collaborate with other key players—clinicians, administration, and information technology, among others," according to J.V.

Make Yourself Valuable to Your Organization

In addition to his recommendation to collaborate in 2015, J.V. also recommended taking steps to increase your value to your organization.

"Healthcare traditionally has been slow and resistant to change, but health reform, brought on by deepening budget cuts and spiraling healthcare costs, is forcing innovation," he said. "This emerging and fast-moving change is filled with opportunities but also diminishing job security. Whether you are a veteran finance leader or a new hire, you [need to] make yourself more valuable to your organization."

"HFMA's CHFP certification can help you get started—it will broaden your knowledge in all areas of finance in healthcare organizations. You can attend conferences or online seminars—HFMA provides free webinars on a diverse set of topics throughout the year," J.V. recommended.

"These and other educational offerings help you to actively seek out other stakeholders in clinical areas to ask them how you could help them achieve their organizational goals of improving patient care, quality of outcomes, and cost reduction," he said.

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New Year's Career Resolutions—From HFMA Members to You

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Along those same lines, here's a New Year's Career Resolution recommendation from Mike Nichols, FHFMA, CPA, and partner at McGladrey, LLP: "Develop skills to understand the implications of all the data we analyze. Not necessarily 'What's in it for me?' but rather 'What does this data mean to our organization?'"



Jim Watson

Slow Down and Communicate

While the new year may bring us new "apps" and advances in technology, **Jim Watson** said his New Year's Career Resolution is to slow down and improve his communication with others—even if it means picking up the phone to have a live conversation with someone when the issue is important.

"Sometimes we move too fast and our interactions with people are too drive-by," said Jim, who is principal for Professional Business Consultants, Inc., and editor of this *First IL Speaks* newsletter.

"I know how I feel when someone is in such a hurry, or too busy, to truly engage or communicate [with me] on an issue," he said. "And I know sometimes I'm the same way. It doesn't feel good from either side of the desk...it smells of self-importance."

Jim referenced e-mail as an example of how our communication can get off-track. "I've learned that sometimes a phone call is a better way to communicate," he said, adding, "As I get older, I realize how many great people I've had the opportunity to work with. I want to slow down and enjoy these people and our relationships and friendships in a better way in 2015."



Brian Washa


While we're on the topic of communication, here's some more sage advice from **Brian Washa**, senior vice president of NorthShore University HealthSystem: "Before talking about another person, be sure the message is a) accurate and b) necessary." Brian added a second pearl of wisdom: "Never pass on an opportunity to lead."

Take Time for Daily Reflections

Finally, this recommendation comes from **David Tomlinson**, executive vice president, CFO and CIO of Centegra Health System in Crystal Lake. David advises us to "Take some time—15 minutes or less—at the end of the day to ask yourself 'What went well? How did I use my last 24 hours? What and how will I do better?'" And the last question he recommends we ask ourselves daily is, in this writer's opinion, the most important question of all: "Who did I serve?"



Dave Tomlinson

Service to others is what healthcare is all about—and it's what makes the difference between just having a job and having a career that you love. 



Vickie Austin

Vickie Austin is a business and career coach based in Wheaton, Illinois, with the mission to "create a world where people love what they do and do what they love." A 20-year veteran of hospital marketing and former director of marketing for *Modern Healthcare* magazine, Vickie speaks at HFMA chapters throughout the country. You can connect with her via email (vaustin@choicesworldwide.com), or the old-fashioned way by calling 312-213-1795.

Visit her blog at <http://vickieaustin.com>.

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Utilization of Healthcare Services *Special Report*

BY KURT SALMON, A GLOBAL MANAGEMENT AND STRATEGY CONSULTING FIRM

Most healthcare leaders would agree that the industry is in the midst of one of the most transformational changes in its history. There is recognition from payors, providers, and government officials that the current system is based on a perverse incentive model that rewards the provision of “sick care” as opposed to “well care.” Tolerance for the current model is rapidly declining. Today, numerous healthcare organizations have started their transformational journeys, and promising models have emerged that are having early successes. While best practices will continue to evolve, the care delivery models and incentive structures that need to be developed for future success are becoming more defined. Networks of providers will be accountable for managing the health of defined populations, and provider reimbursement will be at risk for providing high value care. It is our belief that to have success in this new paradigm, organizations must remove significant amounts of excess utilization and lower the medical cost of their attributed lives. What is not clear is how much utilization will need to be removed and how quickly it must happen. While these two factors will certainly be market dependent, this report explores the expectations of healthcare executives on how healthcare utilization will change in the future and compares their expectations to where we believe healthcare organizations will need to drive utilization levels to be successful in the future.

Factors Impacting Utilization Change

There are numerous factors that will continue to transform healthcare delivery and provider payment models over the next five to ten years. Types of changes include new care delivery models, technology advancements, and new value-based reimbursement methodology. While the healthcare market has experienced movement in the direction of providing “well care” over the last several years, it is our opinion that the movement will accelerate over the next five years as the providers that are first to market with high-value networks will have distinct competitive advantages.

Some of the key factors that will account for organizations removing excess utilization and the associated cost are:

- Programs that educate physicians on ways to provide care more efficiently
- Disease management programs that actively manage patients with chronic conditions and that are at risk
- Utilizing care teams with physician extenders to allow physicians to focus on caring for sicker, high-risk, and chronic patients
- Demand management programs that teach members when to seek medical assistance
- Changes in health plan design that incentivize patients to seek care in more appropriate settings and incentivizes healthy behaviors and preventative care
- Active use of case managers to facilitate treatment of acute and chronically ill patients, and coordinate their care
- Increased care management and changes to reimbursement models that require providers to first use less costly medical options prior to

interventions

- Financial incentives that reward providers for efficient utilization and quality outcomes
- Integrated networks that coordinate the use of appropriate levels of care (e.g., post-acute, ambulatory care) and limit duplication
- Information systems that support the monitoring of utilization and compliance with evidence-based practices
- Clinical data warehouses and analytical tools that locate chronic populations and use predictive modeling to determine high-risk populations to be targeted for early intervention
- Digital channels that utilize algorithm for treatment of minor health issues and the use of telemedicine

Methodology

An electronic survey was distributed in March 2014 to executives and board members at hospitals and health systems around the country. The survey asked respondents to predict changes in utilization of various services. In each case, they were asked if, over the next five years, they expected to see an increase or decrease and the magnitude of the change.

123 surveys were completed. Over 80% of respondents were C-level officers, with the remainder consisting of Presidents, Senior VPs, and board members. Responses came from 38 states. There was broad representation from both small and large hospitals as well as respondents representing independent hospitals and hospitals part of health systems.

The survey responses were compared to the differences between Well Managed and Loosely Managed utilization benchmarks for healthcare delivery systems as defined by actuarial consulting firm Milliman, in its Health Cost Guidelines (HCGs). The HCGs are a set of benchmarks for healthcare utilization and cost, based on data from commercial insurance carriers and Medicare. The two sets of benchmarks make up a spectrum that ranges from organizations with limited medical management activities (Loosely Managed) to organizations that perform extensive medical management activities (Well Managed). The Well Managed benchmarks in aggregate represent a theoretically achievable model of care, but are not necessarily being achieved by any organization across all metrics in today's environment.

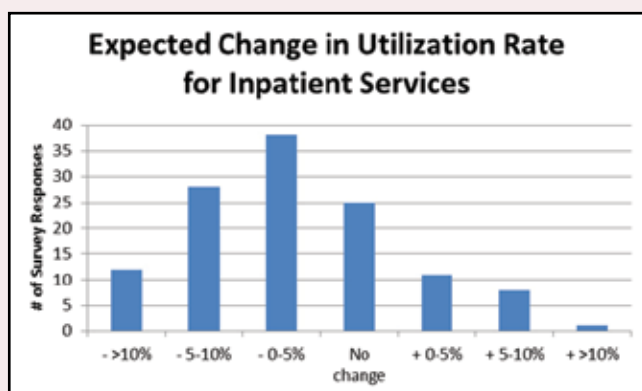
Currently, the utilization for most health care delivery systems falls closer on the spectrum to the Loosely Managed benchmarks than the Well Managed benchmarks. The assumption used for our analysis is that health care delivery systems will be moving toward the Well Managed benchmarks over the course of the next five years (although it is our expectations that the majority of healthcare organizations will take longer than five years to achieve Well Managed utilization levels). Therefore, by measuring the gap between the Loosely Managed and Well Managed benchmarks of the HCGs, we can begin to estimate the potential change in utilization as organizations transition over time and compare this to the expectation of the healthcare executives from the survey.

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Detailed Findings

Inpatient Comparison

When asked how the utilization of all inpatient services, measured by admissions per 1,000 population, would change over the next 5 years, 63% of our survey respondents expected a decrease, 16% expected an increase, and the remaining 21% expected no change. On average, the expected change was a 3% decrease. Among the executives predicting the largest decreases, 5 out of 12 executives specifically cited increased population health management as a primary contributor to the decline.



Based on the estimates built using the HCG data, a well-managed population should see a reduction of inpatient admissions per 1,000 population of 30% relative to loosely managed levels (which are already 10% lower than they were 5 years ago). This figure is based on real data observed from plans and providers that have more mature population health management in place. While it is unlikely that care will fully transition to Well Managed levels over the next five years the discrepancy between the survey estimate and these models (along with recent historical trends) suggests that executives are not preparing for demand changes of this scale.

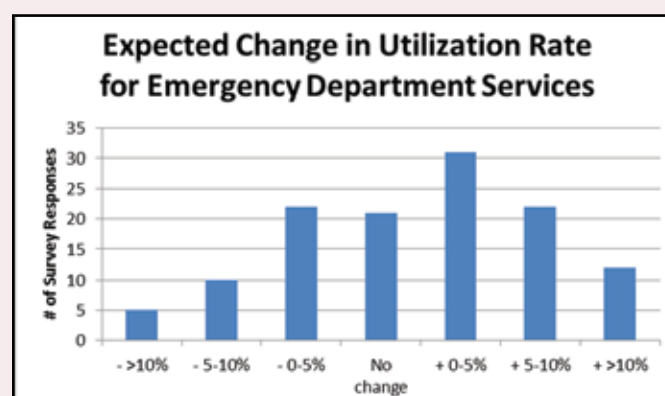
To gain additional insight, we asked similar questions about the utilization of specific inpatient services. Surprisingly, when asked about Cardiovascular, Orthopedic, General Surgery, General Medicine, Oncology, and Neurosciences inpatient services, the average executive expected an increase in utilization for all of these other than General Medicine. Even among those executives who expected overall inpatient services to decrease by at least 5% (40 of the 123), almost two-thirds expected an increase for any particular non-General Medicine service line in the next 5 years. Based on our data-driven models, all of these should expect decreases of 25-35% from a transition to Well Managed population health.

A total of 8 executives referenced the aging population at least once in their responses, with the references spread around the various service areas. We recognize that while changing reimbursement models and population health management should result in decreasing utilization of many services, the steady aging of the US population is expected to counteract the impact somewhat. The percentage of US residents, older than 65, is projected to increase from 14.5% to 16.3% by 2019, which should result in a 4-5% increase in utilization of inpatient days based on current utilization patterns.

Another frequently-cited reason to expect fewer inpatient visits was a shift towards observation care. CMS's changing definition of observation care makes it difficult to project using data, but 77% of survey respondents expect increased utilization, with 30% expecting an increase of at least 10%. This latter figure is by far the most extreme response of any question surveyed.

Emergency Services

Of the areas surveyed, there was the least consensus about the future utilization of Emergency Services. Over 40% of executives expect changes of at least 5%, but they are split on whether that will be an increase or decrease. On the whole, the respondents tended slightly towards increase, with 53% expecting some amount of growth. Of those predicting utilization increases that provided a rationale, the most common was lack of access to primary care. The executives predicting decreased utilization cited competition from urgent care centers, and better utilization of primary and specialty care.



The HCG data suggests a reduction of visits per person of around 35% between a loosely-managed population and a well-managed population. As with inpatient services, the discrepancy between the survey response and this calculated figure suggests executives are not expecting this level of dramatic change in the near future. However, unlike Inpatient Services where the overall trends were in the same direction, there was more disagreement among executives on the direction the use rate will shift in the future.

Diagnostic and Treatment Services

Roughly, 75% of survey respondents expected changes of less than 5% in utilization of both major imaging (CT, MRI, PET) services, and interventional labs (Cath, Electrophysiology, Interventional Radiology). A slight majority did expect some increase in Interventional Labs, resulting in an average projection of 2% growth. For major imaging the average was a small fractional percentage decrease. Here again we see a large discrepancy between the survey responses and the HCGs. In this case, the data suggests that most markets have significant over utilization of Major Imaging and decreases of over 50% utilization will be seen if markets fully transition from Loosely Managed to Well Managed care. Additionally, decreases in many markets could end up being around 30% for interventional procedures.

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The executives expected more changes to surgical services. By asking about both inpatient and ambulatory surgery, it is clear they collectively anticipate a shift in utilization from the former to the latter. Nearly half the respondents expect inpatient surgery to decline, with most of the rest expecting no change. Almost 80% expect an increase in ambulatory surgery, giving an average projection of 4% growth. However, despite this near-unanimity, it is again in conflict with the HCG data, which anticipate declines of 24% in inpatient surgery admissions, and over 40% of facility-based ambulatory surgery visits. These ambulatory surgery figures represent the widest discrepancy between survey response and the data model.

We agree with the respondents, there will be a shift of inpatient to outpatient surgery over time. The HCG data is a current snap shot of benchmarks from Well Managed and Loosely Managed markets that does not take into account the potential for additional services to be performed in outpatient settings over time. That being said, after conducting comparative market utilization analysis for numerous markets we have seen significant difference in the utilization of ambulatory surgical services, where arthroscopic knee surgery may have a 60% higher use rate in one market than the national median or laparoscopic cholecystectomy occurring 120% more often in another market than the national median. To that end, it is our belief that even with the shifting of surgical settings as markets transition to Well Managed ambulatory surgery use rates will decline in the future.

Ambulatory Clinics

The closest we came to agreement between the executives and the data model was in terms of Ambulatory Clinic services. The model predicts very modest declines of 3% for primary care and 11% for specialty clinics, both of which would also be offset by approximately a 2% increase in utilization due to aging. In our survey data, less than 10% of executives projected declines in each of primary care and specialty care clinic utilization. While in both cases large majorities projected small changes, those changes were almost all positive. On average they project a 5% increase in primary care along with 3% in specialty care. It is important to note that the HCG data does not take into account the utilization of digital channels for providing ambulatory care in the future. While predicting the impact of technology on ambulatory clinic use rates is difficult; some healthcare technology experts are projecting 30-40% of visits could be conducted via telephone or through digital channels in the future.

Conclusions

The local aspect of healthcare mean the level of healthcare utilization decreases will happen at differing paces throughout the country; however, the results of the survey show that many healthcare organizations likely do not understand the potential magnitude for utilization reductions and/or believe that most healthcare organizations

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will not have the structures in place to make significant changes over the next five years. It is our opinion that most healthcare organizations will not achieve Well Managed benchmarks over the next five years (although some will surpass them on selected metrics), but organizations should be conducting long-term planning that takes into account these types of reductions. Provider organizations will also need to consider how their asset portfolios will evolve in the future and begin to think in terms of consolidation and delivering care in alternative lower cost settings instead of planning for growth as they have been historically accustomed.

Additionally, the scale of the opportunity to remove duplication and waste and to create value will have a significant impact on most healthcare market places. The first movers to value-based delivery will have a distinct market advantage over those that continue to live in the fee-for-service world if they are able to capture the value that they are creating. Most markets have significant opportunity to lower excess utilization and medical loss. The health systems that are able to do this well will be able to go to market at a substantially lower price point and shift considerable numbers of lives and market share to their delivery network. The impact of which will accelerate the pace of consolidation in the healthcare market. 

About the authors

This report was produced in collaboration with the Health Care Group of **Kurt Salmon**, a global management and strategy consulting firm that enables health care organizations to realize critical strategic advancements, create value from clinical integration, transition to population health management and achieve performance improvement. For further information, visit: www.kurtsalmon.com/healthcare.

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GLOBAL
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Medicare Physician Fee Schedule Announcement: An Annual Tug of War?

BY CHRISTINA CLAUSSNER, SENIOR HEALTHCARE CONSULTANT, PBC ADVISORS, LLC

SCMS Table 93

Every November, Medicare updates reimbursement for the following calendar year and provides a combined impact summary by major physician specialty in what is known as Table 93. This highly anticipated document is essentially “a list of winners and losers in the annual tug and pull for a fixed pot of federal money” (Cheryl Clark, for HealthLeaders Media, December 2, 2014). In essence, it is a zero sum game where there are winners, physicians whose reimbursement will be increased, and there are losers, physicians whose reimbursement is decreased to offset that of the winners.

Three Components that Impact a Physician's Income via Medicare (and most other payors)

There are three basic components that impact Medicare reimbursement: work value (aka RVUs), practice expense and malpractice insurance costs. The correlation between these components cannot be ignored, especially with the historical rise in practice expenses and malpractice costs. Any type of work value change, even minor, can swing the long term viability pendulum for a physician practice.

November 2014 Table 93

Analysis of the combined impact data from Table 93 of previous years as well as the anticipated impact for 2015, shows that in the last four years alone there have been significant cumulative changes in reimbursement to various specialties. For example, while specialties such as chiropractic (14%), psychiatry (8%), geriatrics (8%) and primary care (10% by 2016) have seen significant cumulative increases in reimbursement, other specialties have not fared as well. Diagnostic testing providers have seen their reimbursement decrease at 23%, independent labs 20% and radiology providers 17%, to name a few.

The steady bump in psychiatry, geriatrics and primary care reimbursement can be attributed to the government's preparation for increased volume of duals entering the program and the corresponding behavioral health and preventative care they will require. Primary care physicians are enjoying a steady increase year over year but are realizing that the increase in pay comes with an increase in responsibility. Under the Medicare Advantage programs, primary care physicians are being required to participate in increased care management expectations which can be time consuming. To further incentivize the additional workload, starting in January 2015 CMS will reimburse PCPs an additional monthly amount of \$42.60 per patient with two or more co-morbid conditions whereby the physician meets certain criteria pertaining to non-face to-face interaction (CPT cod 99490).


Each year, the combined impact column reflects the anticipated overall impact to the following year by specialty—with understanding that this impact may fluctuate should there be any corresponding conversion


factor (CF) adjustments allowed by the regulation. The current statute allows for a negative CF reduction to be implemented effective April 1, 2015.

Value Based Payment Modifier Reimbursement (VM)/PCRS Reimbursement Changes

The Affordable Care Act Value Based Payment Modifier reimbursement (VM) is supposed to become effective January 1, 2015, whereby it would be applied to a select number of specialties and codes and would then be fully implemented by January 1, 2017. Implementing this could create a swing in reimbursement anywhere from a negative 4 percent to an increase of 4 percent.

What to Expect

The debates surrounding fee schedule changes and reimbursement methodology changes continue and CMS is facing strong opposition from the AMA and other medical associations. Expect 2015 to be another challenging year in health care! 



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Expanding the Care Provider Mix: Transitioning to the Use of APRNs and Other Physician Extenders

BY DAN YUNKER, PAST PRESIDENT, FI HFMA, SVP, METROPOLITAN CHICAGO HEALTHCARE COUNCIL, CEO, LAND OF LINCOLN HEALTH

Health care delivery models are changing more rapidly now than ever before. Frequent readers of the HFMA newsletter will have heard this from me before, in one form or another. Despite sounding like a broken record, it is a point that I always remember as I work with my team to develop solutions to today's health care challenges.

With that in mind, MCHC surveyed our membership a few years ago and asked what challenges hospital and health system leaders were facing in the clinical setting. Far and away, the top response was that organizations large and small wanted better guidance on the ways in which they could best utilize the advance practice registered nurses (APRNs) and physician assistants (PAs) that they were hiring at an unprecedented rate to enhance patient care.

In response to that growing need, we worked with UHC to gather data from health care organizations across the county on APRN and PA best practices. Today, that data bank holds information from more than 171 institutions in 26 different states, and it represents more than 19,000 APRNs and PAs in 50 clinical specialty areas. That information was deployed to create the Center for Advancing Provider Practices

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Expanding the Care Provider Mix: Transitioning to the Use of APRNs and Other Physician Extenders

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(CAP2), a first-of-its-kind, nationwide database aimed at helping health care organizations best utilize each member of their respective provider teams.

For example, CAP2 has worked with one major health system to facilitate a series of system-wide team meetings that reduce variation, standardize models of care, and build infrastructure to support best practices for their APRNs and PAs.

Subsequently, the system was able to standardize their credentialing and privileging processes; models of care in primary, specialty and long-term care settings; job descriptions; annual performance review forms and processes; orientation and onboarding; and competency assessment forms and processes for the APRNs and PAs throughout their organization. The implementation of this infrastructure allows all providers to practice to the top of their license and helps the health system achieve the goals of the Triple Aim by increasing access to care, improving patient outcomes and reducing unnecessary costs.

This example helps prove an important point—as a cohesive unit, physicians and advanced practitioners are able to more effectively treat patients and increase value-driven care. A coordinated care team with all providers at top of license is the most effective way to improve quality of treatment, advance health care outcomes, reduce admissions and decrease health care costs for the growing patient populations. Beyond that, all care team members are happier and more efficient, because they can put their particular skill sets to the best use.

Gone are the days of one-on-one visits exclusively with a primary care physician. And gone are the days of patients asking, “What’s a nurse practitioner?” Today, a patient may see one of several care team members, all of whom are more than adequately trained to address both basic and advanced patient needs. This not only saves the patient money, but can, if done properly, support health care organizations’ ability to meet the triple aim by optimizing the provider team.

Leading healthcare organizations nationally are embracing these strategies. On November 20, MCHC and UHC hosted more than 250 health care leaders from across the country at the CAP2 Summit in Chicago, in order to continue the nationwide dialogue on best practices, enhanced patient care and increased efficiencies through the use of expanded care teams. I was privileged enough to attend a portion of that conference, and the excitement and passion I saw at the event was more than catching.

As an organization, MCHC has been a believer in the potential of expanded care teams for a number of years, and we have noticed that health care organizations are eager to incorporate advanced practitioners into their care teams. I urge my fellow HFMA members, if they haven’t already, to seriously consider adopting that view. Expanded care teams are the future of our rapidly changing health care landscape, and APRNs and PAs are poised to play an integral role in controlling costs, improving quality, promoting innovation, expanding care—and helping health care stay competitive. 🌱



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Three Ways Healthcare Providers Can Improve Their Underpayment Detection and Resolution Processes

BY CORY HERENDEEN AND DANIEL WALLACE, CROWE HORWATH LLP

Healthcare providers are under more financial pressure than ever and looking for ways to squeeze every dollar of cash collections from patient services revenue. Maximizing cash collections requires analysis, or underpayment detection, to determine whether payers are applying contractual discounts correctly. Three components are critical to implement best-practice underpayment detection and resolution processes: evaluating an organization's risk of underpayment, identifying and collecting closed-balance underpayments, and implementing process improvements to maximize future collections.

A comprehensive zero-balance review typically identifies undetected underpayments totaling between 0.5 and 1.2 percent of net revenue; if worked in a timely and effective manner, they can be turned into quick cash and directly boost a provider's bottom line. Underpayment identification requires an accurate expected-payment calculation as well as sound documentation—registration, coding, and billing—in advance of reimbursement by the payer. Underpayment sources can include “clean claims,” which are based on a payer's electronic or paper remit response and hide payment reductions as “contractual adjustments.” Clean-claim underpayments also can occur from internal errors—for example, if implant charges are mapped incorrectly to Revenue Code 270 instead of 274 or 278.

Evaluating an Organization's Risk of Underpayment

A provider should consider its risk of underpayment and evaluate its detection efforts. These factors increase the risk for underpayments and lost patient services revenue:

- Complex managed care contract structures—for instance, stop loss, case rates, and implant/drug exclusions
- Clinically complex patient services—for example, a high case mix index
- An understaffed or inexperienced collections team
- Not having a zero-balance audit/review
- A recent system conversion

Identifying and Collecting Closed-Balance Underpayments

An internal or external review of zero-balance accounts should occur on an ongoing basis to maximize patient services collections. Such a review should include these steps:

- Review accounts in a timely fashion. Many payers have time limits for appeals, so waiting to perform a zero-balance review can result in uncollectible underpayments or forfeited cash collections.
- Perform a comprehensive review. Many zero-balance reviews target high-risk and high-dollar underpayment areas such as stop loss and case rates. However, it is critical to perform a thorough review of all accounts, including government and managed care payers, as underpayment patterns can be identified in smaller-dollar/higher-volume areas.

- If necessary, escalate the response to outstanding underpayments. Successfully resolving some underpayments takes collections expertise and overturning payer denials. Sometimes the response to underpayments needs to be escalated through payer meetings or even legal action.

Implementing Process Improvements to Maximize Future Collections

Each zero-balance underpayment has a reason for lacking identification—for instance, inaccurate system pricing, manual miscalculation, incorrect registration, or poor mapping of Revenue Code charges. A zero-balance review should reveal process improvement techniques so underpayments are eliminated in the future or at least identified in a timely manner.

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Three Ways Healthcare Providers Can Improve Their Underpayment Detection and Resolution Processes

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The following examples of underpayment issues list the cause for lack of identification and recommendation(s) to resolve these accounts:

Example 1: payer A – stop loss

- Cause: The expected-pricing tool is unable to accurately price second-dollar stop-loss reimbursement.
- Recommendations: Pull a monthly report of all payer A accounts that have charges greater than the stop-loss threshold. Manually price qualifying accounts and appeal all underpayments.

Example 2: payer B – case rate


- Cause: The expected-pricing tool is not calculating the craniotomy case rate for accounts with International Classification of Diseases-9 (ICD-9) procedure code 01.23 (reopening of the craniotomy site).
- Recommendation: Update expected-pricing “logic” to calculate the craniotomy case rate for all payer B accounts that have ICD-9 procedure code 01.23.

Example 3: payer C – implants

- Cause: Due to “implant invoices not submitted in the contractual time frame for responding to information requests,” payer C did not make an implant payment.
- Recommendations: Payer C’s contract guarantees reimbursement of implants at a percentage of charges; therefore, no implant invoice is required for implant payment. Generate an appeal for reimbursement, and escalate to payer C’s managed care liaison/provider relations representative. Going forward, pull monthly reports for all payer C accounts that have implant charges to receive correct implant reimbursement, and educate collections staff to respond properly to payer C’s implant invoice requests.

Benefiting From the Three Components

By using the three components, a provider can assess whether payers meet contractual obligations. This assessment ultimately gives a quick cash boost directly to the provider’s bottom line. In addition, data from underpayments can be supplemented with data from denials and accounts receivable aging to evaluate holistic payer performance. The provider may use performance metrics to compare like payers—for example, managed care or managed government

payers—and hold organizations accountable in payer/provider meetings and contract negotiations. Such settings also can be effective forums for addressing unfair payment patterns or systematic underpayment issues, increasing the likelihood of successful resolution. 

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5 Lessons in Applying Predictive Analytics Within a Hospital

BY JEFF STRAUSS, VICE PRESIDENT, CLIENT SERVICES JVION

To rank the best adult and children's hospitals, U.S. News analyzed data for nearly 5,000 centers. The 2014-15 rankings cover medical centers across the country and span 16 medical specialties from cancer to urology. Results of the analysis reveal that some hospitals are more expert than others in caring for patients with life-threatening or rare conditions. And people facing such health challenges need every bit of help they can get.

Want to find innovation in healthcare that helps protect high and rising risk patients? Look to Mississippi and Alabama. That wasn't a typo. Ranked number 50 and 48, these states have the dubious distinction of being the unhealthiest in the nation. So it should come as no surprise that the hospital systems serving these populations are desperate for solutions that will help improve the lives of their patients and the health of their communities. But this desire to stop patient suffering is impeded by limited budgets, which are compounded by populations that are the poorest by median income. These hospitals not only have to serve the sickest people in our nation, they have to do it with the smallest number of resources and fewest dollars.

Within each state, there are certain illnesses and adverse events that are top of mind. For Mississippi, Acute Myocardial Infarction, or heart attacks, are number one on the list. According to one physician, one out of every 100 people discharged from his facility will have a heart attack within a year. In Alabama, the focus is on reducing Hospital Acquired Conditions (HACs)—those adverse events that happen because of faulty processes and result in increased patient suffering and/or death. HACs kill 75,000 people each year. According to the Centers for Disease Control, there are more people dying of HACs than of diabetes in the U.S.

In both states, the focus is on prevention. They want to stop adverse events and the resulting losses by predicting illnesses so they can intervene. Working with constrained IT departments, a practically zero-dollar budget, and a clinical population skeptical of new technologies, providers in both states had to find a way to bring predictions into the hospital. **These are the five lessons learned through this process:**

The solution has to be right. Predictive solutions are nothing if they aren't accurate. Moreover, accuracy has to translate across all use cases. Any solution that is designed for healthcare should be able to demonstrate its accuracy before it is ever put into production. That accuracy should get better with every new piece of data run through the machine. In other words, the solution should "learn" a population through the data it analyzes.

The solution has to fit into the real world of a hospital. This means that it has to be easy to deploy, fit into the existing workflow, require very little time and effort from internal resources, and use data that is relatively easy to extract. Most of all, it has to pay for itself in reduced cost and waste.



Knowing when a model is wrong is just as important as knowing when a model is right. Clinicians hear alarms going off all day. Technology is constantly demanding their attention. When the technology incorrectly identifies a risk, it undermines trust in the system and use of the technology. Predictive solutions should have a well-established methodology in place for identifying under-performing algorithms and removing them from the model.

Predictive solutions should come pre-seeded with use cases.

Surprisingly, most don't. Instead they offer a platform on which a provider can build models that will address pain points. The problem with this approach is that it takes a long time to build a model; it requires internal resources from IT, administration, and clinical operations to test and validate the solution; and it may miss opportunities where predictive analytics can save resources and improve health outcomes. A predictive solution should already come with models built to address what we know are big problems—like heart attacks and HACs.

Associations are powerful. Clinical care is focused on using evidence that explains causation, like randomized clinical trials. But the associations identified using advanced analytic solutions can create enough evidence to enable action. A nurse explained how she views patient-level predictive analytics this way: it is just like a blood test—it tells me there is a risk and I take action based on that risk.

In both states, provider leadership understands the role of predictive analytics in driving prevention and improving patient health. As we shift toward value-based models and coordinated care, prevention will be the center of our healthcare industry. And given that you can't prevent what you can't predict, predictive analytic tools are positioned to change what we do, from treating illness to preventing it. 🧠

You and Your 340B Program: Are You Compliant or Confused?

BY VENSON WALLIN AND BILL BITHONEY, MD, THE BDO CENTER FOR HEALTHCARE EXCELLENCE AND INNOVATION

What Is the 340B program?

The 340B program is a means through which providers, known as “covered entities,” can offer pharmaceuticals to a greater number of eligible patients than they could at traditional manufacturer pricing. This is because the program requires that manufacturers sell the drugs to the eligible providers at a discount, thereby enabling a larger number of those in need to get the assistance they need with purchasing their prescriptions. The 340B program is very popular for this very reason: covered entities are able to purchase drug supplies at the 340B discounted price and then bill the patient’s insurance company the traditional rate. This “margin” generates much needed profit for some of the more income-challenged providers, while having minimal impact on the Medicare and Medicaid program costs. The patient wins, the provider wins, and the government programs win. Providers understand the upside, and annual 340B drug spending by covered entities exceeds six billion dollars. Approximately one-third of U.S. hospitals participate in the program. The spending and number of participating providers is forecast to increase significantly during the coming years.

In 1992, Congress created the 340B program via Public Law 102-585, the Veterans Health Care Act of 1992, which is otherwise known as Section 340B of the Public Health Service Act. The law requires drug manufacturers that participate in the Medicaid program to agree to provide discounts on covered outpatient drugs purchased by government-supported facilities, or “covered entities.” Examples of “covered entities” include disproportionate share hospitals, sole community hospitals, rural referral centers, critical access hospitals, and children’s hospitals and cancer hospitals exempt from the Medicare prospective payment system. Enrollment periods for those providers seeking to participate in the program are open on a quarterly basis. Administration of the 340B program is performed by the Office of Pharmacy Affairs (OPA) of the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services.

Achieving Compliance with 340B Program Guidelines

Compliance pertaining to a 340B program is relative. A provider may consider themselves in compliance with the guidelines of the program based on their understanding of these guidelines, whereas HRSA and the OPA may consider the provider to be noncompliant based on their interpretation of these same guidelines. These divergent opinions are a result of a set of rules that are written in a somewhat general manner, excluding the detailed implementation regulations that are common to other HHS programs. HRSA recognizes the need for more clarity on the part of the covered entities and is actively working to close the interpretation “gap” and to achieve more compliance within the program.

HRSA has heard the rumblings from the industry and Congress over the past several years regarding the 340B program and the need for

more detailed directions to minimize both unintentional violations of the program as well as intentional efforts to take advantage of the interpretation “gap” to prosper to an extent not anticipated by the authors of the program. Audits in recent years by HRSA and the Office of the Inspector General (OIG) of HHS have confirmed the fact that covered entities are having challenges meeting full compliance with guidelines, particularly in the areas of diversion and duplicate discounts. Another key factor in meeting compliance requirements identified through the audits is the degree to which providers utilize contract pharmacies and their oversight of such. The use of contract pharmacies, while occurring in the minority of covered entities at this point, is growing and there is a wide disparity in their treatment and oversight. HRSA has strongly recommended the use of independent audits of contract pharmacies to address compliance.

Increased Focus on Integrity and Compliance

So where does one go from here? Good question and one that the HHS OIG and HRSA intend to address in the immediate future. They are both being very active in publishing clarifying documents and preparing to conduct more extensive audits of 340B programs. The HHS OIG 2014 Work Plan contains initiatives pertaining to the 340B program, including a focus on contract pharmacy compliance by covered entities. In February 2014, the OPA issued a program update that addressed contract pharmacy compliance and the continued focus on the program’s integrity. In its June 2014 program update, HRSA discussed an additional six million dollars that Congress had set aside for the 340B program. The additional funding is being used to establish a new branch of HRSA—Program Performance and Quality—which is tasked with overseeing program integrity. HRSA stressed that program integrity has always been a focal point of their staff, but that the new branch will now enable them to devote even more emphasis on this topic. And in its July 2014 program update, HRSA further clarified its audit process, reaffirming its focus on increased audits and the intent to no longer issue preliminary audit reports but to only issue final reports. The commitment to a renewed attention to compliance through increased audits is evident through these updates and publications, and covered entities would be advised to prepare for the inevitability of an increase in 340B program audits and that they may soon fall within HRSA’s radar.

“Mega-Reg” to Provide Clarification

Many facilities may be feeling somewhat alarmed by this enhanced focus on program integrity in that they believe they may need more guidance to ensure that their program is truly compliant. As discussed before, heretofore detailed implementation guidance on the 340B program has been found to be somewhat lacking, and compliance became an “interpretation of the rules” exercise. Now, with more expected of them, the covered entities are in need of specific clarification of the rules and HRSA is preparing to provide such guidance. The much discussed “mega-reg” that HRSA is expecting to issue will provide specific guidance on issues such as the definition

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You and Your 340B Program: Are You Compliant or Confused?

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of an eligible patient, compliance requirements for contract pharmacy arrangements, hospital eligibility criteria, and the eligibility of off-site hospital facilities.

Throwing a potential curve into HRSA's plans is the recent (May 2014) decision by the United States District Court for the District of Columbia (USDCDC), which held that HRSA lacked the ability to issue the regulation regarding orphan drugs. HRSA had attempted to promulgate limitations on the use of orphan drugs by certain covered entities. However, the USDCDC found that the 340B regulation itself limited HRSA's ability to promulgate regulations to only those areas dealing with the administrative dispute resolution process, calculation of ceiling prices, and civil monetary penalties. Furthermore, orphan drugs were not deemed to be included in the definition of any of these three areas. Therefore, HRSA was found to not have the authority to issue any regulations pertaining to them.


Covered entities may wonder why this is important if orphan drugs are not a large part of their 340B program. The importance lies in the ability of HRSA to issue and enforce the "mega-reg." HRSA has so far chosen not to appeal the USDCDC finding, and it must decide, before proceeding, whether the issues covered by the "mega-reg." would survive a likely court challenge in light of the USDCDC decision, and whether a further "tweaking" of the regulation should occur prior to its

actual issuance. At this point, HRSA has indicated that they continue to look to move forward with the "mega-reg."

Conclusion

It is very clear that the history of the 340B program being loosely regulated and enforced is just that—history. HRSA, the OPA and the HHS OIG all have the 340B program high on their list of priorities and they are committed to ensuring a more consistent implementation of the program and to strengthening its integrity. Through audits and publication of clarifying guidance, they are working with covered entities to achieve those goals. Covered entities should be proactive in assessing the compliance of their 340B programs and taking steps to document compliance and/or perform corrective efforts to become compliant. Steps may include performing internal assessments of policies and procedures or partnering with external agents to assist with these assessments, performing audits of the program components, obtaining independent audits of contract pharmacy arrangements, and developing a routine process of monitoring new HRSA program updates and their impacts, including the new "mega-reg." By taking these steps, covered entities can begin to move the gauge from "confusion" to "compliance." 🌀

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Administration to Bar Insurance Plans Lacking Hospital Coverage

BY HFMA EDITORIAL STAFF

So-called skinny health insurance plans for large employers that have been deemed to meet the minimum requirements for Affordable Care Act (ACA) healthcare coverage under the Obama administration's "benefits calculator" will be barred by coming regulations, according to an IRS announcement.

<http://www.irs.gov/pub/irs-drop/n-14-69.pdf>

Plans lacking hospitalization coverage "do not provide the minimum value intended by the minimum value requirement," the IRS wrote in Tuesday's statement.

According to the announcement, the IRS and the U.S. Department of Health and Human Services (HHS) plan to issue regulations in 2015 that will no longer allow large employers to avoid ACA penalties by offering low-cost insurance plans that lack coverage for hospitalization. However, skinny plans that have already been finalized and that go into effect before March will be allowed to continue.

Nearly one in six large companies planned to offer such skinny coverage to their employees in 2015, according to an August survey by a major employer group. Such coverage was intended to allow companies with more than 100 workers to avoid penalties of about \$2,000 per employee under the ACA's long-delayed employer mandate, which goes into effect in 2015.

<https://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=234>

The planned change to the online insurance calculator—a spreadsheet created by the Obama administration to help employers confirm whether their coverage meets ACA requirements—followed growing concerns raised by patient advocates and hospital representatives.


<http://www.cms.gov/ccio/resources/regulations-and-guidance/index.html>

Defenders of the skinny care plans, which generously covered routine physician care with low deductibles and out-of-pocket costs, said they fit the demands of some employees, according to published reports.

ACA Marketplace Impact

Importantly, employees covered by plans lacking hospital coverage can qualify for ACA marketplace insurance subsidies—assuming they meet income requirements—since their employer's plans will not count as providing "minimum value," as defined by the ACA.

The ACA defined minimum value as plans that covered at least 60 percent of the total allowed costs of benefits.

The IRS statement did not address whether employers with existing skinny plans would still face fines required under the ACA for large companies whose employees buy subsidized marketplace coverage. 

Addressing Nurse Burnout Can Decrease Cost Related to Infections

BY AMERICAN JOURNAL OF INFECTION CONTROL


Reducing burnout in registered nurses may lead to lower rates of healthcare associated urinary tract and surgical site infections, according to a study published in the August issue of American Journal of Infection Control.

Researchers studied urinary tract and surgical site infection data at 161 acute care Pennsylvania hospitals, along with survey data from 7,076 registered nurses employed at these hospitals. They found a significant association between patient-to-nurse ratios and both types of infections among patients.

The higher rate of infections in hospitals in which nurses care for more patients seems to be related at least in part to the high levels of nurse burnout associated with heavier patient caseloads. Hospitals in which burnout was reduced by 30 percent had a total of 6,239 fewer infections,

for an annual cost savings of up to \$68 million, according to the study. The cost savings estimates are based on data from a Centers for Disease Control and Prevention report on the direct medical costs of healthcare associated infections.

Researchers found that increasing a nurse's workload by even one patient resulted in increases in both types of infections. The average rate of urinary tract infection across hospitals was seven infections per 1,000 patients, and the average rate of surgical site infection was slightly less than five infections per 1,000 patients.

Researchers hypothesize that the cognitive detachment associated with high levels of burnout may result in inadequate hand hygiene practices and lapses in other infection control procedures. 

Costs, Funding for Ebola Preparation Evolving

BY RICH DALY, HFM SENIOR WRITER/EDITOR

All hospitals have been advised to prepare for possible Ebola cases, but the costs and funding of that preparation remain uncertain.

Although the Centers for Disease Control and Prevention (CDC) is moving toward the designation of “specialized centers” to treat Ebola cases, it continues to urge all hospitals to prepare to identify and—at least initially—treat Ebola patients. The degree to which hospitals will need to increase training, add equipment, and set aside space to treat such patients will vary widely depending on their previous preparation for infectious diseases.

Nicole Lurie, MD, assistant secretary for preparedness and response for the U.S. Department of Health and Human Services, urged all hospitals to undertake medical grand rounds to identify improvements needed in their ability to identify and treat Ebola patients, conduct first-case drills, and train staff.

“In reality, we think it’s extremely unlikely that most of your institutions are ever going to see a patient with Ebola,” Lurie said in an Oct. 20 conference call with providers. “However, it is the case that all of your institutions need to be ready if that eventuality happens.”

Costs Vary

Hospitals trying to meet the latest CDC standards for Ebola detection and care have publicly reported estimated total preparation costs as high as \$500,000. But costs may vary widely by organization. For instance, although some hospitals are building containment areas for suspected Ebola cases, the CDC said hospitals that lack designated rooms could place suspected Ebola patients in a private room with a bathroom and contact the agency around the clock for further instructions.

The estimated cost of Ebola preparation at Stony Brook University Hospital on Long Island—one of eight New York hospitals designated by the state to treat Ebola cases—is about \$150,000, with about half of that in previously obtained equipment, according to Leo DeBobes, director of emergency preparedness at Stony Brook. Much of the cost is for personal protective equipment (PPE), but other costs include \$6,000 for negative pressure isolation pods to transport Ebola patients between and within hospitals, DeBobes said.

Another New York hospital designated for Ebola treatment, SUNY Upstate University Hospital in Syracuse, expects to incur Ebola costs “in the hundreds of thousands” of dollars, according to CEO John McCabe, MD. Most of these costs are related to Ebola training for “a couple hundred” clinical staff, physical plant modifications, and duplicative testing equipment to be based in the four-bed Ebola unit.

Identifying Costs

Janis Orłowski, MD, interim chief healthcare officer for the Association of American Medical Colleges (AAMC), said her organization is still developing cost estimates for preparing hospitals to treat Ebola patients under a tiered system. That approach would add 10 regional hospitals that are trained and equipped at the level of the nation’s



existing four infections disease specialized hospitals. A secondary tier of regional hospitals would house suspected and early stage Ebola cases, which would not require advanced levels of care.

A leading cost underscored by academic medical centers designated as go-to treatment facilities in their states is training of staff designated to care for an Ebola patient.

“If one lesson is to be learned from the Dallas situation, it is the need to train, train, train,” Orłowski said about the first domestic Ebola case at Texas Health Presbyterian Hospital Dallas.

Although the cause of Ebola’s spread from the first U.S. patient to two nurses who treated the patient at Presbyterian Dallas remains unknown, the latest CDC guidelines for hospitals—issued Oct. 20—called for “rigorous and repeated training” for medical personnel who treat such patients. Even one misstep in donning and doffing PPE, for instance, can result in transmission of the virus, according to infectious disease experts.

<http://www.cdc.gov/vhf/ebola/hcp/index.html>

Stony Brook’s estimated costs do not include all training for at least 200 personnel on donning and doffing PPE because such training is expected to be ongoing “for years,” DeBobes said. The hospital’s standards for training are even more stringent than those called for by the CDC.

“This is not the kind of training where you can go sit for 10 minutes and watch a video; it’s an hour’s worth of hands on training and then you keep at it until you get it right,” McCabe said about what he expects will be monthly retraining of designated staff for the foreseeable future.

Preparation steps at academic medical centers vary widely due to variations in their existing infectious disease treatment infrastructure, Orłowski said. For instance, some have functioning biohazard rooms

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Costs, Funding for Ebola Preparation Evolving

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to treat Ebola patients, but at least three facilities are examining the cost and feasibility of bringing wards back to that level of care or re-commissioning empty buildings for those patients.

Upstate University Hospital is re-activating a mothballed bone marrow transplant unit to house any future Ebola cases, McCabe said.

"Hospitals are following recommended protocols," said Chad Mulvany, director, healthcare finance policy, operational initiatives for HFMA. "This potentially requires the purchase of additional PPE to meet revised guidelines and incurring additional labor costs for training and dissemination of the new CDC guidelines. Although hospitals have well-developed plans for getting the word out and training for new guidelines, the challenge—beyond the significant cost—is the immediacy of the need to get it done while maintaining hospital operations."

Funding Sources

To help fund hospital preparation efforts across the country, the AAMC is in discussions with the Obama administration on a "supplemental funding" package, and the hospital advocacy group is developing estimates of what would be needed for facilities in the proposed tiered approach, Orlowski said. Such funding could come as part of a congressional funding bill that will not be written until legislators return to work after the midterm elections. A spokeswoman for the American Hospital Association said her organization also is developing cost estimates to present to congressional appropriators.


One funding source frequently mentioned is the Hospital Preparedness Program (HPP), which has had its funding cut from \$500 million a decade ago to \$255 million this year. However, that fund for natural or manmade disaster preparation sends money to state and local public health systems, which may in turn choose to reimburse hospitals for the costs of training, equipment, or education. A CDC spokeswoman said hospitals could use HPP funding to purchase supplies or train personnel, but it was unknown whether hospitals have been awarded Ebola preparation funds because such "sub-awardees" do not have to report back until the end of the year.

Kentucky has used an HPP grant to develop a tabletop training exercise for the steps that hospitals should follow when handling a suspected Ebola case.

<http://www.kyha.com/kentucky-public-health-ebola-tabletop-exercise/>

Another federal funding source hospital advocates are examining is the Federal Emergency Management Agency, which reimburses hospitals for some costs following disasters.

Beyond any preparatory steps hospitals undertake in the immediate future, Orlowski said, those facilities will need to continue preparations throughout at least the next 12 months due to the possibility that the three cases, so far, are only part of a "stuttering start" to a wider epidemic.

Rich Daly is a senior writer/editor in HFMA's Washington, D.C., office. Follow Rich on Twitter: @rdalyhealthcare. 



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HFMA Event Summary in Pictures

Fall Summit

October 30 & 31, 2014, Eaglewood Resort & Spa, Itasca, IL



Al Staidl, Alice V. Runyan Chapter Achievement award



Andrew Stefo, Reeves Silver Merit Award



Brian Katz, Muncie Gold Merit Award



Brian Washa, Reeves Silver Merit Award

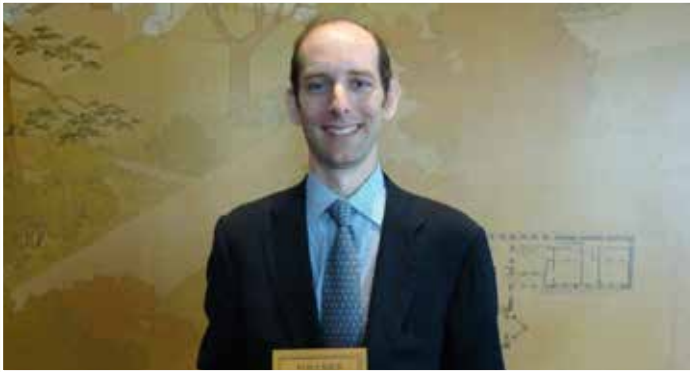


Carl Pellitieri and DanYunker



Elizabeth Lively and Nichole Magalis

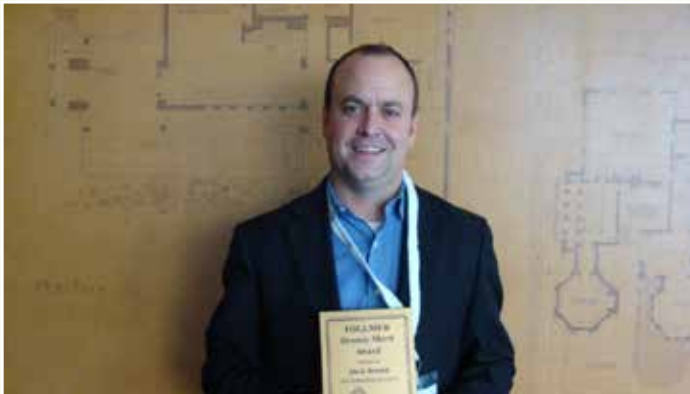
(continued on page 22)



Adam Lynch, Follmer Bronze Merit Award



HFMA 2014 Fall Session, CHFP Certification



Tim Heinrich, Follmer Bronze Merit Award



Jose Sanchez, Frank McHugh, Michael Geldner, Mike Vivoda, and Jim Watson



Joseph Fifer and Kevin Brennan



Revenomics 102 Instructors: Kausar Karwa, Sally Marano, Patrick McDermott, Rita Moran, Susan Pfister, Char Mazzuca, and Michelle Sutherland



Halloween Reception: Steve Chrapla and Arthur Baxter



Halloween Reception: Paula Dillon Michelle Holtzman Steve Chrapla and Ron Snyder

First Illinois HFMA Fall Summit Huge Success!

The FIHMFA Fall Summit was held October 30-31 at the Eaglewood Resort & Spa in Itasca. Close to 400 people attended the event, which featured eight educational tracks, 25 program sessions, and social networking events.

The summit kicked off with a roundtable discussion on Illinois Medicaid reform featuring Michael Gelder, senior advisor of health policy for Governor Quinn; Mike Vivoda, president, North Region, Northwestern Medicine; Jose Sanchez, CEO, Norwegian American Hospital, and Frank McHugh, senior director of finance, University of Chicago Medical Center. The session underscored the vast differences in hospital market positions driven purely by differences in the payor mix.

The Day 2 keynote speaker was Joe Fifer, FHFMA, CPA, current HFMA national president and CEO, who presented with Kevin Brennan, CPA, FHFMA, EVP/Finance, CFO and treasurer at Geisinger Health System. These two nationally renowned speakers shared stories and best practices from their vast experiences around the country.

Across the eight educational tracks and program sessions, attendees had the opportunity to hear from industry leaders on current issues, opportunities and best practices in finance, treasury, healthcare reform, reimbursement, and revenue cycles. Other highlights included The Claro Group facilitating an educational track dedicated to the HFMA CHFP Certification Practicum, Patrick McDermott's "Revenomics" sessions (both 101 and 201), Mike Nichols "Medicare Cost Reporting" sessions, and a Halloween party at the end of Day 1, which provided a fun, festive, social networking opportunity at the end of the learning day.

By all accounts the two-day event was a huge success, a great learning venue with top tier speakers on relevant topics, but also a program that offered an opportunity to have some fun, relaxation and socialization with our colleagues. And at 400 attendees, one of the most attended events in FIHFMA history. A big kudos to everyone involved in the planning and execution of the 2014 FIHFMA Fall Summit!



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First Illinois HFMA 2015 Scholarship Applications Now Being Accepted

Applications Due February 27, 2015

First Illinois Chapter HFMA is proud to announce its eighth annual scholarship program for its members and their children seeking higher education. Scholarship recipients are chosen by the Scholarship Selection Committee made up of representatives from the chapter.

The chapter is pleased to award five scholarships—one for \$5,000, one for \$4,000 and three for \$2,000. The First Illinois HFMA application cycle is as follows:

- First Illinois HFMA applications can be downloaded from the First Illinois Chapter website: <http://www.firstillinoishfma.org/>.
- All applications must be postmarked by February 27, 2015.
- All applications should be mailed to: Vincent Pryor, Edward Hospital, 801 South Washington, Naperville, IL 60540.
- All scholarships will be awarded no later than May 15, 2015.

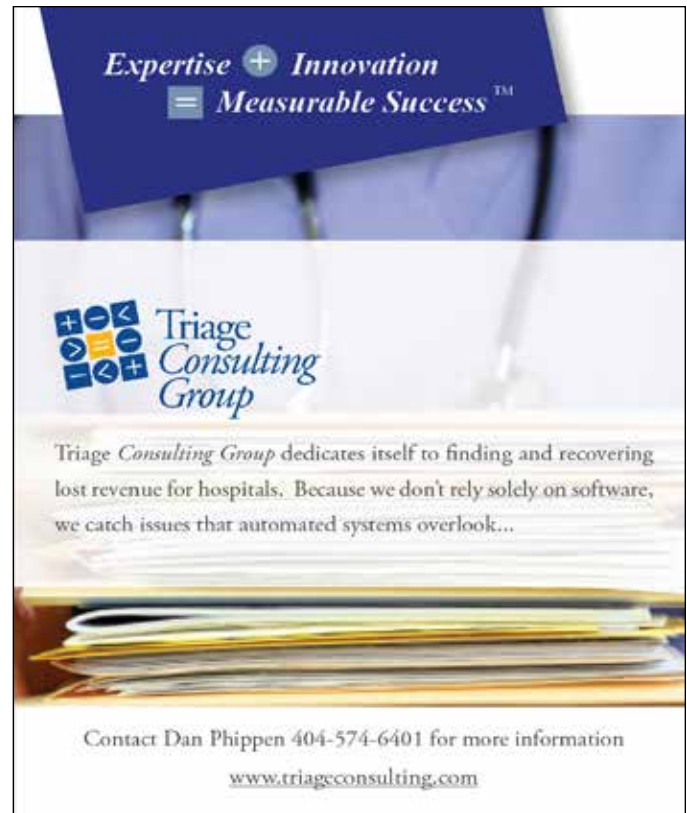
The eligibility requirements for applicants for the 2014-2015 academic year are as follows:

- Applicants must attend or plan to attend an accredited college, university or proprietary/trade school.
- High school seniors and undergraduate students are eligible to apply.
- Only one scholarship per student will be awarded during their lifetime.
- First Illinois Chapter HFMA members and their children are eligible for scholarships.
- Applicants must be U.S. citizens.

The application consists of six parts: the application, a letter of recommendation from a faculty member, two letters of reference, an essay/testimonial, academic transcripts and an interview with the selection committee.

Scholarship recipients and their parents will be recognized at the annual installation dinner and awards ceremony in July 2015.

Please direct any questions to Vince Pryor at vpryor@edward.org or 630-527-3035.



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Look for more details to be announced soon.

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Articles for *First Illinois Speaks* should be written in a clear, concise style. Scholarly formats and styles should be avoided. Footnotes may be used when appropriate, but should be used sparingly. Preferred articles present strong examples, case studies, current facts and figures, and problem-solving or "how-to" approaches to issues in healthcare finance. The primary audience is First Illinois HFMA membership: chief financial officers, vice presidents of finance, controllers, patient financial services managers, business office managers, and other individuals responsible for all facets of the financial management of healthcare organizations in the Greater Chicago and Northern Illinois area.

A broad topical article may be 1000-1500 words in length. Shorter, "how-to" or single subject articles of 500-800 words are also welcome. Authors should suggest titles for their articles. Graphs, charts, and tables (**PDF or JPG only**) should be provided when appropriate. Footnotes should be placed at the end of the article. Authors should provide their full names, academic or professional titles, academic degrees, professional credentials, complete addresses, telephone and fax numbers, and e-mail addresses. Manuscripts should be submitted electronically, on computer disk or by e-mail as a Microsoft Word or ASCII document.

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